

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/19/2011	
NAME OF PROVIDER OR SUPPLIER PLAINFIELD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/19/11</p> <p>Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Plainfield Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of 189 and had a census of 135 at the time of</p>			K0000	<p>Preparation and/or execution of this Plan of Correction in general, or any corrective action does not constitute an admission or agreement by Plainfield Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws.</p> <p>Plainfield Health Care Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on November7th, 2011</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0021 SS=E	<p>this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/25/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as the kitchen was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect any resident, staff or visitor in the vicinity of the west kitchen door into the main dining room.</p>			K0021	<p>K 021:It is the policy of this facility to ensure doors serving hazardous areas such as the kitchen are held open only be a device arranged to automatically close the door upon activation of the fire alarm system.All residents have the potential to be affected by this finding.Maintenance Director installed a magnetic door stop</p>		11/07/2011

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	<p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the west kitchen door into the main dining room was held open by a door stop on the floor which would not allow the door to close automatically upon activation of the fire alarm system. Based on interview at the time of observation, the Assistant Maintenance Technician stated the west kitchen door is propped open with a door stop only after meals in the main dining room have concluded but acknowledged the west kitchen door was propped open with a door stop on the floor and the door would not close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p>				<p>that is wired to the fire alarm panel to the west kitchen door. As part of the preventative maintenance program, Maintenance Director will continue to monitor doors for proper release upon activation of the fire alarm system. Dietary staff has been in-serviced on not propping doors open in the kitchen. Any staff found to be non-compliant with the points of the in-service will be further educated by the Dietary Supervisor and/or progressively disciplined as appropriate.</p>		

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K0025 SS=E	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 openings through 1 of 7 smoke barriers were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the attic smoke barrier wall near the Orchard Drive office area.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the following was noted above</p>			K0025	<p>K 025:It is the policy of this facility to ensure openings through smoke barriers are protected to maintain the smoke resistance of the smoke barrier.All residents have the potential to be affected by this finding.The smoke barrier wall separating the Orchard Drive office area from the elevator corridor has been firestopped and is in the closed position.As part of the preventative maintenance program, Maintenance Director will continue to monitor smoke barriers to ensure smoke resistance. Any concerns will be immediately addressed and corrections will be made.</p>		11/07/2011

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K0044 SS=E	<p>the ceiling in the smoke barrier wall separating the Orchard Dive office area from the elevator corridor: a. four, one inch in diameter openings for cables which are each not firestopped. b. one, three foot by four foot access panel which was in the open position. Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged four openings in the smoke barrier wall above the ceiling by the Orchard Drive office area and the elevator corridor which were not firestopped and one access panel in the smoke barrier wall which was in the open position.</p> <p>3.1-19(b)</p>						
	<p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 3 of 3 access doors in attic fire barrier walls maintained a two hour fire barrier and are equipped with positive latching to provide the protection needed for a two hour fire barrier. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4. LSC 7.2.4.3.4 requires any opening in fire barriers be protected as provided in 8.2.3.</p>			K0044	<p>K 044:It is the policy of this facility to ensure access doors in the attic fire barrier walls maintain a two hour fire barrier and are equipped with a latching system to provide protection needed for a two hour fire barrier.All resident have the potential to be affected by this finding.The maintenance director repaired the attic fire barrier near room 42, 47, and 136 to ensure the fire barrier walls maintained a two hour fire barrier</p>		11/07/2011

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	<p>LSC 8.2.3.2.1 requires fire doors to be installed in accordance with NFPA 80. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect residents, staff and visitors in the vicinity of the attic fire barrier near Room 42, Room 47 and Room 136.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the following was observed:</p> <p>a. the attic fire barrier wall near Room 42 had four layers of five eighths inch drywall and the access panel door in the fire barrier wall which measured three feet by four feet consisted of two layers of five eighths inch drywall and was not equipped with a positive latching mechanism.</p> <p>b. the attic fire barrier wall near Room 27 had four layers of five eighths inch drywall and the access panel door in the fire barrier wall which measured three feet by four feet consisted of two layers of five eighths inch drywall and was not equipped with a positive latching</p>				<p>and are equipped with a latching system to provide protection needed for a two hour fire barrier. The maintenance director will continue to monitor fire barrier walls to ensure compliance with fire barrier regulations. Any concerns will be addressed immediately and corrections will be made.</p>		

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K0048 SS=E	<p>mechanism.</p> <p>c. the attic fire barrier wall near Room 136 had four layers of five eighths inch drywall and the access panel door in the fire barrier wall which measured three feet by four feet consisted of two layers of five eighths inch drywall and was not equipped with a positive latching mechanism.</p> <p>Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged each attic access door in the fire barrier walls was not rated at two hours and was not equipped with a positive latching mechanism.</p> <p>3.1-19(b)</p>			K0048			11/07/2011
	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(1) Use of alarms</p> <p>(2) Transmission of alarm to the fire department</p>				<p>K 048:It is the policy of this facility to ensure the written Fire Emergency Procedure addresses the use of ABC type fire extinguishers and the K class fire extinguishers in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The facility Disaster Plan Manuel has been revised to include the proper fire suppression measures in the</p>		

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	<p>(3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Emergency Procedure" for Plainfield Health Care Center during record review with the Assistant Maintenance Technician from 9:45 a.m. to 11:40 a.m. on 10/19/11, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Assistant Maintenance Technician acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p>				<p>kitchen.Dietary Staff has been inserviced on the use of ABC type fire extinguishers and the K class fire extinguishers in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Any staff who fail to comply with the points in the inservice will be further educated and/or progressively disciplined.Maintenace Department will continue to monitor the facility fire suppression measures to ensure compliance.</p>		

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K0052 SS=C	<p>3.1-19(b)</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current-carrying capacity and capable of interrupting the maximum short-circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point</p>			K0052	<p>K 0052:It is the policy of this facility to ensure the Fire Alarm 3 breaker panel box is locked.The maintenance director placed a lock on the fire alarm breaker panel box.The maintenance director will continue to monitor the lock on the fire alarm breaker circuit as part of the Preventative Maintenance Program. Any concerns will be addressed immediately and corrections will be made.</p>		11/07/2011

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K0062 SS=B	<p>of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the "Fire Alarm 3" breaker panel located next to the downstairs unit emergency generator identified the circuit and breaker for the fire alarm system for the facility but the breaker panel box in which it was located was not locked.</p> <p>Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged the fire alarm system breaker circuit in the Fire Alarm 3 breaker panel was not locked.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with</p>			K0062	<p>It is the policy of this facility to ensure the sprinkler heads in the facility are maintained per NFPA 13, Standard for the Installation of Sprinkler Systems. The Maintenance Director repaired the missing escutcheon plates on the sprinkler near the Orchard</p>		11/07/2011

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	<p>a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect any resident, staff or visitor in the vicinity of the Orchard Drive office area.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, the following areas each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area:</p> <p>a. Orchard Drive fire panel room. b. Orchard Drive clean linen room. c. Orchard Drive kitchen.</p> <p>Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged the Orchard Drive fire panel room, clean linen room and kitchen each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area.</p> <p>3.1-19(b)</p>				<p>Drive fire panel, near the Orchard Drive clean linen room, and near the Orchard Drive kitchen. The Maintenance Director will continue to monitor the facility sprinkler system as part of the Preventative Maintenance program. Any concerns will be addressed immediately and corrections will be made.</p>		

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K0067 SS=F	<p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors if the modifications had not been made.</p> <p>Findings include:</p> <p>Based on observation and interview with the Assistant Maintenance Technician during the tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, all resident rooms were using the egress corridor as a return air system, however, the facility has modified the HVAC (Heating, Ventilation, and Air Conditioning) system so activation of the fire alarm system will</p>		K0067	<p>Corrective Action (K067): It is the policy of to ensure the fire dampers in the ductwork at smoke barriers are inspected and maintained at least every four years. All residents have the potential to be affected by this finding. The maintenance supervisor inspected all 80 fire dampers in the facility and all are in working order. All repairs needed were completed at time of inspection. The facility has developed a tracking form for the inspection of the fire dampers which will be kept in the Facility Preventative Maintenance Log. The inspections and maintenance will be completed annually. The Maintenance Director is responsible for maintaining these records. Please accept this letter as an application for a waiver for the K67 deficiency. This waiver request has been requested and approved on previous Life Safety Code recertification. This waiver is supported by the following facts: a. When the fire alarm system is triggered, there is an automatic shut down on the air handlers. b.</p>		11/07/2011	

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K0076 SS=E	<p>stop the supply air fans. Additionally, the supply air fans have duct detectors located downstream of the air filters that when activated, shut down the fan's operation. Finally, the HVAC ducts do not penetrate any fire or smoke walls, eliminating the need for the installation of smoke dampers interconnected to the fire alarm system to prevent the transfer of smoke from one compartment to other smoke compartments. Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged all resident rooms were using the egress corridor as a return air system.</p> <p>3.1-19(b)</p>				<p>None of the existing cold air returns go through a firewall. Based upon the inspector's recommendation for a waiver, and the facts outlined above, we request a waiver for K 67.</p>		
	<p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical outlets in the oxygen storage and transfilling room were located at least five</p>				<p>K 0076:It is the policy of this facility to ensure electrical outlets in the oxygen storage room are located at least five feet above the floor.The Maintenance Director capped the electrical</p>		

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	<p>feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11.d which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect any residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 10/19/11, there are two electrical outlets on the wall in the oxygen storage and transfilling room. Each electrical outlet was one foot and six inches in height from the floor of the oxygen storage and transfilling room. Eight liquid oxygen storage tanks were observed being stored in the oxygen storage and transfilling room. Based on interview at the time of observation, the Assistant Maintenance Technician acknowledged two electrical outlets are on the wall of the oxygen storage and transfilling room and each outlet was less than five feet above the floor.</p>				<p>outlets in the oxygen room and placed a blank cover over the outlets. The Maintenance Director will continue to monitor the outlets in the oxygen room and any concerns will be immediately addressed as part of the Preventative Maintenance Program.</p>		

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K0144 SS=C	<p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to provide complete documentation for testing 2 of 2 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Load Test-Downstairs Unit" and "Generator Load Test-Shed Unit" documentation with the Assistant Maintenance Technician during record review from 9:45 a.m. to 11:40 a.m. on 10/19/11, the Downstairs Unit and the Shed Unit emergency generators were each run on a monthly basis for at least thirty minutes each</p>		K0144	<p>It is the policy of this facility to provide complete documentation for testing the emergency generators providing power to the emergency lighting systems. The Generator Load Test documentation is completed by the Maintenance Director each month. This documentation provides generator run tests for at least thirty minutes each month, percentage of load capacity or minimum gas exhaust temperature, and the logs record the time to transfer power from the main source to each emergency generator. The Generator Load Test documentation is part of the facility Preventative Maintenance Program. Any concerns will be addressed immediately and corrections will be made.</p>		11/07/2011	

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	<p>month for the period of 10/18/10 through 09/19/11 but the logs utilized by the facility did not record the time to transfer power from the main source to each emergency generator. Based on interview at the time of record review, the Assistant Maintenance Technician acknowledged the transfer time to transfer power to each emergency generator was not recorded for each month.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a monthly load test for 2 of 2 emergency generators was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS</p>						

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	<p>nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Load Test-Downstairs Unit" and "Generator Load Test-Shed Unit" documentation with the Assistant Maintenance Technician during record review from 9:45 a.m. to 11:40 a.m. on 10/19/11, the Downstairs Unit and the Shed Unit emergency generators were each run on a monthly basis for at least thirty minutes each month for the period of 10/18/10 through 09/19/11 but the logs utilized by the facility did not record the minimum exhaust gas temperature or the percentage of load capacity for the monthly load test conducted on 06/13/11 for each emergency generator. Based on interview at the time of record review, the Assistant Maintenance Technician acknowledged neither the percentage of load capacity or minimum exhaust gas temperature was recorded for the 06/13/11 monthly load test for each emergency generator.</p>						

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